STATE OF CONNETICUT
State Innovation Model
Template Design Work Group
Meeting Summary
Friday, April 8, 2016
9:30 am – 11:30 am

Members Present: Mary Ellen Breault, Jennifer Herz, Steven Wolfson, Mary Bradley, Steven Moore, Patrick Charmel, Catie Olinski, Amy Tippett-Stangler, Tekisha Everette, Deremius Williams

Members Absent: James Cardon, Russell Munson, Michelle Vislosky, Hugh Penney, Fiona Mohring, Hugh Penney, Thomas Meehan, Russell Munson, Cheryl Lescarbeau

Other Participants: Mark Schaefer, Jenna Lupi, Sandra Czunas, Thomas Woodruff, John Freedman, Cathy Cuddy, Alyssa Ursillo, Rachel Pieciak, Member of public – Scott Braithwaite

The Meeting was called to order at 9:35 am.

1. Review of Work Group Goals

Alyssa Ursillo gave a brief overview of the work group goals. The purpose of the work group is to:

- Make recommendations for guiding principles that may be adopted by private employers
- Make recommendations for V-BID provisions to be included in the template such as: services to incentivize, clinical conditions to target, approaches for incentivizing the use of high-value providers and low value services to be discouraged
- Make recommendations for template variations based on employer-type (e.g. small v. large etc.) and employer culture
    - Mary Bradley suggested that the breadth of employer types and cultures should be reflective of the national landscape as well as the Connecticut landscape

2. Review of V-BID Plan Design Guiding Principles

The work group reviewed the proposed guiding principles for the V-BID plan templates.

Mary Ellen Breault asked that the language for principle regarding mental health parity reflect that it is required, not simply "allowed".

Jennifer Herz commented that there should be a guiding principle about understanding the employer perspective and how this may impact their costs and ROI, as well as the constraints that may be placed on small employers by state laws. This will help ensure employer buy-in.

Steven Wolfson suggested that the definition of high-value providers acknowledge that cost goes beyond just price considerations. The Work Group agreed that "cost" does not simply reflect price.

Thomas Woodruff brought up the principle regarding V-BID implementation as part of a "consumer-centric approach" and whether or not this principle should be elaborated upon. Freedman will circulate the latest version of the consumer-centric V-BID approach slide deck that the consumer members developed. This may serve as a part of the V-BID toolkit/framing document for implementation.

3. V-BID Template Review and Discussion

A. Discussion of V-BID Options Infographic

Ms. Bradley suggested that the language of the examples be reworded to use "cost sharing" instead of "copays". Ms. Bradley expressed some concern about the relevancy of disease management programs as a participatory requirement for receiving V-BID benefits.

Patrick Charmel explained that while health plans will become more autonomous in disease management program implementation and oversight, there is still a need for collaboration between employers, health plans and providers to align incentives for all three parties.

Ms. Breault commented that federal guidelines require an alternative for people who cannot meet an outcome if incentive structure is outcomes-based. While the group agreed most employers would already be aware of this federal regulation, this should be acknowledged when presenting the outcomes-based option in the templates.

B. Discussion of V-BID Option 1: Change incentives for specific services for *all members* targeted by age and gender

Ms. Ursillo began the discussion for the V-BID templates by framing the templates in the context of the overall SIM goals. This can be achieved by aligning the consumer-side incentives with provider-side incentives based on the SIM Quality Council provisional measure set. Mark Schaefer added that the Quality Council will be meeting soon to align the measure set with the CMS and AHIP recommendations that recently came out, and they will then be posted for public comment.

Ms. Bradley raised a concern about the wording of "all members", because some of the services included are not recommended as evidence-based services for all members. This wording may be confusing for employers.

The Group discussed whether Health Maintenance Exams should be targeted for all members or if the demographic should be specific to recommended frequencies for certain demographics (e.g. age, gender).

Mr. Charmel voiced his concern about the problem of attribution when patients do not see their PCP every year, which was echoed by Dr. Wolfson. Tekisha Everette added that incentivizing consumers should help to bridge the gap between providers and patients.

Ms. Ursillo then directed the conversation to the discussion of low-value services. Several Work Group members were challenged by this option from an implementation standpoint because it effectively "punishes" consumers for receiving services that they may not recognize as being low-value or nonessential. Ms. Breault noted that this would be difficult to implement as part of a benefit design, and should instead be handled on the provider side. Ms. Everette echoed this concern about penalizing the consumer for services a provider may recommend. John Freedman pointed out that consumers may not know what high value services are either, but those are being incentivized in this model, and this is just another way to influence consumer behavior. Mr. Schaefer emphasized that all V-BID plans will require educating consumers on which services are high value v. low value. Ms. Breault noted this will really complicate communications materials for employees. Ms. Bradley

added that the adoption of incentives and disincentives for all member services will vary by employer and employer culture.

Ms. Ursillo suggested that this option could be presented as an additional V-BID option that could be implemented with guidance provided, but would not be part of the minimum recommended set of options/services. Ms. Bradley raised concern about having a minimum set of recommended options. Ms. Herz asked that the project team clarify what the intended outcome of these templates will be, as that will impact what should be recommended. She also noted that examples of V-BID services remain simple especially for small employers to avoid overwhelming the employers and to maintain employer interest and buy-in. Ms. Bradley suggested that examples of V-BID plans by provided by employer-type, such as what employers with HDHP have done. She offered to provide examples of these.

Ms. Everette suggested that prenatal and postnatal care be added to the list of services to incentivize. Dr. Wolfson suggested that cancer screenings also be added to the list of services and that emergency department usage be removed as a potential low-value service to discourage. The Group reached the consensus that services already covered by the ACA be added to the template but be indicated as such.

C. Discussion of V-BID Option 2: Change incentives for specific services by *clinical condition*

The Group discussed conditions and services to be targeted as part of a V-BID plan. Dr. Wolfson agreed with the services listed but suggested removing hydralazine from the list.

Mr. Moore suggested adding substance use disorders as a condition and including screening, treatment and follow up services for patients with this condition. Ms. Bradley suggested that pre-health conditions (e.g. diabetes) be added to the list of clinical conditions. The Group briefly discussed whether certain chronic conditions, such as pre-diabetes, can be identified by claims and how this may be important for which services will be recommended to employers. Mr. Schaefer brought up the importance of integrating the use of electronic medical records into these efforts and that this is a SIM goal. While health plans identifying these types of conditions may not yet be possible, this should be retained as a goal for the future.

D. Discussion of V-BID Option 3: Change incentives for *visits to high value providers*

The Group discussed defining high value providers. Ms. Ursillo framed the discussion by emphasizing that the SIM Quality Council provisional measure set provides an opportunity for alignment on defining high value in terms of quality. The Group generally agreed that this measure set could be leveraged.

Deremius Williams anticipated that stakeholders may take issue with the word "high" in "high-value" and trying to define that, and suggested using "value provider" instead. Mr. Charmel noted that he did not feel the semantics mattered, but that the definition would.

In addition to defining value in terms of cost and quality**,** Ms. Everette and other members of the Group suggested that access, availability and patient centeredness also be considered. Ms. Williams suggested that providers who have undertook certain efforts to transform

patient engagement and management (e.g. extended hours, communication, patient centeredness etc.) be considered as important aspects to value.

Dr. Freedman asked the Group if they agreed that the purpose of the group was not to actually define high value, (e.g. which quality metrics are included) but that the Group make recommendations as to which criteria should be considered when identifying high value providers, such as cost quality, accessibility, patient centeredness, etc. The Group generally agreed with this.

Dr. Wolfson expressed concern with the tiered network approach, in that it is often difficult to determine how providers are defined as tier one v. tier two or three. He noted that if tiered networks were used in defining value that the criteria by which providers are tiered be transparent.

E. Discussion of V-BID Option 4: Change incentives for visits for *specific services* only if member visits a *high value provider*

The Group acknowledged the potential challenge of accessibility to implementing this V-BID option, especially if the required services are long-term. Dr. Wolfson noted that the example of Blue Groove was distinct from the examples of using Centers of Excellence, because it focused on treatment of chronic conditions, rather than treatment for one episode. Access may be an issue in this case. The Group agreed that accessibility is an important factor in identifying high value providers.

F. Discussion of V-BID Structure

The Group discussed if they would recommend enrollment in V-BID plans be voluntary or compulsory. Ms. Herz suggested that the pros and cons of having a mandated versus participatory enrollment needs to be explained to employers.

Dr. Woodruff described his experience with the state employee Health Enhancement Program, which had a voluntary enrollment structure. He emphasized the key was to have a strong incentive structure to encourage enrollment – the HEP plan had a high premium penalty for those who did not enroll, which incentivized employees to engage in the program. Dr. Woodruff also noted that this plan is now being implemented for municipal employees, but in this case participatory is compulsory with an opt-out component. Some members of the Group noted that if enrollment is compulsory, those who want the incentives will be those who participate, and those who do not will not participate. These strategies can be effective in persuading individuals to enroll and to stay in the plan.

The meeting adjourned at 11:30 am.